

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14177

Reg. Dist. No.

14187

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Pages 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Susan Anne</i> MARYLAND		a. STATE <i>Md.</i>	b. COUNTY <i>Sudlersville</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Bethelsville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		<i>Sudlersville</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM?	
<i>/</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Harry</i>	Middle <i>Anthony</i>
4. DATE OF DEATH		Month <i>12</i>	Day <i>30</i>
		Year <i>1958</i>	
5. SEX		6. COLOR OR RACE	7. MARRIED
<i>Male</i>		<i>White</i>	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED
8. WIDOWED		9. DATE OF BIRTH	
		<i>June 16-1884</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Painter</i>		<i>House Painter</i>	<i>Md. -</i>
12. CITIZEN OF WHAT COUNTRY?		<i>US</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Henry Austin</i>		<i>Sarah Sylvester</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT
		<i>218-20-8799</i>	<i>Mrs. Beulah Austin</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <i>Sudlersville</i>	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Fractured skull - broken leg</i>	
812X		INTERVAL BETWEEN ONSET AND DEATH <i>at dinner</i>	
Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause first.			
(b)			
DUE TO			
(c)			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Motor vehicle and pedestrian</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>12/30/58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>
		20f. (City or town) <i>Sudlersville</i>	(County) <i>Q.A.</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Walter F. Fisher</i>		DATE SIGNED <i>12/30/58</i>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 3, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Church Hill Cem.</i>		22d. LOCATION (City, town, or county) <i>Church Hill Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellow Wilmington Md.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <i>JAN 5 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

ST. MARYS RIVER, ONTARIO, CANADA
HABO TO STATION IN THE MOUNTAINS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14188

CERTIFICATE OF DEATH

14178

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville, Md		c. LENGTH OF STAY IN 1b 21 Fe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville						
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sellees		First	Middle	Lost	4. DATE OF DEATH Bailey	Month 12	Day 4	Year 1958		
5. SEX Male		6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892		9. AGE (in years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Waterman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles Bailey				14. MOTHER'S MAIDEN NAME Lena Nixon						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWI		16. SOCIAL SECURITY NO. —		17. INFORMANT Harrison Bailey, Stevensville, Md		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 3d.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from _____ Oct. 1958 to Dec. 1958 that I last saw the deceased alive on Dec. 2, 1958, and that death occurred at 638 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)							DATE SIGNED 12/18/58	
ACTUAL SIGNATURE Ervin G. Hoyt		M.D.								
PHYSICIAN'S NAME (Type) Ervin G. Hoyt MD										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-58		22c. NAME OF CEMETERY OR CREMATORIUM Battleground Cem		22d. LOCATION (City, town, or county) Stevensville Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE James S. Daniel, Easton, Md		ADDRESS		24a. REC'D BY REGISTRAR DEC 10 '58		24b. REGISTRAR'S SIGNATURE John S. Evans				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14179

14183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY QUEEN ANNE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE PENNA. b. COUNTY Lancaster.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Queenstown	c. LENGTH OF STAY IN 1b 30 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster, PENNA 75x3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 23 HAGER Str.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) IRENE C. DEAN	First	Middle	Last			
4. DATE OF DEATH Dec 24	Month	Day	Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 4 1887			
9. AGE (in years from birthday) 71 yr.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) PENNA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Crumbling	14. MOTHER'S MAIDEN NAME Elizabeth Wolf					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Doris A. Hitch, 521 MANOR Rd, Glen Burnie, Md.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Suddenly INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE W. Henry Fisher	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12/24/58		
22a. BURIAL, CREMATION; REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC 27, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Conestoga Memorial Park	22d. LOCATION (City, town, or county) Lancaster Co. PENNA.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Donald H. Batten, Jr., Batten Bros., Centerville, Maryland.	ADDRESS	24a. REC'D BY REGISTRAR DEC 29 '58	24b. REGISTRAR'S SIGNATURE John H. Batten			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14180

14190 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington, Crompton adult life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crompton Millington, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Padtown RFD		d. STREET ADDRESS Padtown RFD	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wm. Henry Elliott		First	Middle
		Lost	
4. DATE OF DEATH Dec. 2, 1958		Month	Day
		Year	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Dec. 15, 1881	
		9. AGE (In years <small>(last birthday)</small> yrs.) 78	
		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY laborer	11. BIRTHPLACE (State or foreign country) Maryland
		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles Unknown Elliott		14. MOTHER'S MAIDEN NAME Harriett Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? no		16. SOCIAL SECURITY NO. 217-30-7590	17. INFORMANT Mary Lee
		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		2 years	
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Vascular Disease		unknown	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 19, 1958, to Dec. 2, 1958, that I last saw the deceased alive on Dec. 2, 1958, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Robert W. Farr, M.D.		Chester	
PHYSICIAN'S NAME (Type)		Chestertown, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/58	22c. NAME OF CEMETERY OR CREMATORIUM Ewingtown Cem.
		22d. LOCATION (City, town, or county) Queen Anne Co. nr. Church Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE DEC 5 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOND

WATER STATE PLANNING & DEVELOPMENT BOARD
THE STATE OF TEXAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14191 CERTIFICATE OF DEATH

14181

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>		c. LENGTH OF STAY IN lb <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>		d. STREET ADDRESS <i>Route 3, Box 102</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Route 3, Box 102</i>				d. STREET ADDRESS <i>Route 3, Box 102</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>thomas</i>		First	Middle <i>Gould</i>	Lost	4. DATE OF DEATH Month <i>12</i>	Day <i>15</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 8, 1885</i>	9. AGE (in years last birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tenant</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Gould</i>		14. MOTHER'S MAIDEN NAME <i>MARY E Green</i>		Address <i>Thomas & Gould f. Centreville, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>4</i>		17. INFORMANT <i>Thomas & Gould f. Centreville, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
						Cerebral Hemorrhage	
						Cerebral Thrombosis in left hemiplegia	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 1, 1958</i> to <i>Dec. 10, 1958</i> , that I last saw the deceased alive on <i>Dec. 10, 1958</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Irvin G Hoyt</i>		ADDRESS (Street, city or town, state) <i>Queen Anne, Md.</i> DATE SIGNED <i>12/18/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/18/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Gould Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Centreville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest Dashiell, Easton, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>DEC 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>C. W. S. Knud</i>	

WYOMING STATE LIBRARY-SURVEY

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	TIME OF DEATH	PLACE OF DEATH
John Smith	65	M	Heart Disease	10:00 AM	Hospital
Spouse	60	F	Stroke	11:00 AM	Hospital
Child	2	M	Pneumonia	12:00 PM	Hospital
Child	1	F	Pneumonia	1:00 PM	Hospital
Parent	85	M	Heart Disease	2:00 PM	Hospital
Parent	80	F	Stroke	3:00 PM	Hospital
Spouse	62	M	Pneumonia	4:00 PM	Hospital
Child	3	F	Pneumonia	5:00 PM	Hospital
Child	4	M	Pneumonia	6:00 PM	Hospital
Parent	88	M	Heart Disease	7:00 PM	Hospital
Parent	83	F	Stroke	8:00 PM	Hospital
Spouse	64	M	Pneumonia	9:00 PM	Hospital
Child	5	F	Pneumonia	10:00 PM	Hospital
Child	6	M	Pneumonia	11:00 PM	Hospital
Parent	89	M	Heart Disease	12:00 AM	Hospital
Parent	84	F	Stroke	1:00 AM	Hospital
Spouse	65	M	Pneumonia	2:00 AM	Hospital
Child	7	F	Pneumonia	3:00 AM	Hospital
Child	8	M	Pneumonia	4:00 AM	Hospital
Parent	90	M	Heart Disease	5:00 AM	Hospital
Parent	85	F	Stroke	6:00 AM	Hospital
Spouse	66	M	Pneumonia	7:00 AM	Hospital
Child	9	F	Pneumonia	8:00 AM	Hospital
Child	10	M	Pneumonia	9:00 AM	Hospital
Parent	91	M	Heart Disease	10:00 AM	Hospital
Parent	86	F	Stroke	11:00 AM	Hospital
Spouse	67	M	Pneumonia	12:00 PM	Hospital
Child	11	F	Pneumonia	1:00 PM	Hospital
Child	12	M	Pneumonia	2:00 PM	Hospital
Parent	92	M	Heart Disease	3:00 PM	Hospital
Parent	87	F	Stroke	4:00 PM	Hospital
Spouse	68	M	Pneumonia	5:00 PM	Hospital
Child	13	F	Pneumonia	6:00 PM	Hospital
Child	14	M	Pneumonia	7:00 PM	Hospital
Parent	93	M	Heart Disease	8:00 PM	Hospital
Parent	88	F	Stroke	9:00 PM	Hospital
Spouse	69	M	Pneumonia	10:00 PM	Hospital
Child	15	F	Pneumonia	11:00 PM	Hospital
Child	16	M	Pneumonia	12:00 AM	Hospital
Parent	94	M	Heart Disease	1:00 AM	Hospital
Parent	89	F	Stroke	2:00 AM	Hospital
Spouse	70	M	Pneumonia	3:00 AM	Hospital
Child	17	F	Pneumonia	4:00 AM	Hospital
Child	18	M	Pneumonia	5:00 AM	Hospital
Parent	95	M	Heart Disease	6:00 AM	Hospital
Parent	90	F	Stroke	7:00 AM	Hospital
Spouse	71	M	Pneumonia	8:00 AM	Hospital
Child	19	F	Pneumonia	9:00 AM	Hospital
Child	20	M	Pneumonia	10:00 AM	Hospital
Parent	96	M	Heart Disease	11:00 AM	Hospital
Parent	91	F	Stroke	12:00 PM	Hospital
Spouse	72	M	Pneumonia	1:00 PM	Hospital
Child	21	F	Pneumonia	2:00 PM	Hospital
Child	22	M	Pneumonia	3:00 PM	Hospital
Parent	97	M	Heart Disease	4:00 PM	Hospital
Parent	92	F	Stroke	5:00 PM	Hospital
Spouse	73	M	Pneumonia	6:00 PM	Hospital
Child	23	F	Pneumonia	7:00 PM	Hospital
Child	24	M	Pneumonia	8:00 PM	Hospital
Parent	98	M	Heart Disease	9:00 PM	Hospital
Parent	93	F	Stroke	10:00 PM	Hospital
Spouse	74	M	Pneumonia	11:00 PM	Hospital
Child	25	F	Pneumonia	12:00 AM	Hospital
Child	26	M	Pneumonia	1:00 AM	Hospital
Parent	99	M	Heart Disease	2:00 AM	Hospital
Parent	94	F	Stroke	3:00 AM	Hospital
Spouse	75	M	Pneumonia	4:00 AM	Hospital
Child	27	F	Pneumonia	5:00 AM	Hospital
Child	28	M	Pneumonia	6:00 AM	Hospital
Parent	100	M	Heart Disease	7:00 AM	Hospital
Parent	95	F	Stroke	8:00 AM	Hospital
Spouse	76	M	Pneumonia	9:00 AM	Hospital
Child	29	F	Pneumonia	10:00 AM	Hospital
Child	30	M	Pneumonia	11:00 AM	Hospital
Parent	101	M	Heart Disease	12:00 PM	Hospital
Parent	96	F	Stroke	1:00 PM	Hospital
Spouse	77	M	Pneumonia	2:00 PM	Hospital
Child	31	F	Pneumonia	3:00 PM	Hospital
Child	32	M	Pneumonia	4:00 PM	Hospital
Parent	102	M	Heart Disease	5:00 PM	Hospital
Parent	97	F	Stroke	6:00 PM	Hospital
Spouse	78	M	Pneumonia	7:00 PM	Hospital
Child	33	F	Pneumonia	8:00 PM	Hospital
Child	34	M	Pneumonia	9:00 PM	Hospital
Parent	103	M	Heart Disease	10:00 PM	Hospital
Parent	98	F	Stroke	11:00 PM	Hospital
Spouse	79	M	Pneumonia	12:00 AM	Hospital
Child	35	F	Pneumonia	1:00 AM	Hospital
Child	36	M	Pneumonia	2:00 AM	Hospital
Parent	104	M	Heart Disease	3:00 AM	Hospital
Parent	99	F	Stroke	4:00 AM	Hospital
Spouse	80	M	Pneumonia	5:00 AM	Hospital
Child	37	F	Pneumonia	6:00 AM	Hospital
Child	38	M	Pneumonia	7:00 AM	Hospital
Parent	105	M	Heart Disease	8:00 AM	Hospital
Parent	100	F	Stroke	9:00 AM	Hospital
Spouse	81	M	Pneumonia	10:00 AM	Hospital
Child	39	F	Pneumonia	11:00 AM	Hospital
Child	40	M	Pneumonia	12:00 PM	Hospital
Parent	106	M	Heart Disease	1:00 PM	Hospital
Parent	101	F	Stroke	2:00 PM	Hospital
Spouse	82	M	Pneumonia	3:00 PM	Hospital
Child	41	F	Pneumonia	4:00 PM	Hospital
Child	42	M	Pneumonia	5:00 PM	Hospital
Parent	107	M	Heart Disease	6:00 PM	Hospital
Parent	102	F	Stroke	7:00 PM	Hospital
Spouse	83	M	Pneumonia	8:00 PM	Hospital
Child	43	F	Pneumonia	9:00 PM	Hospital
Child	44	M	Pneumonia	10:00 PM	Hospital
Parent	108	M	Heart Disease	11:00 PM	Hospital
Parent	103	F	Stroke	12:00 AM	Hospital
Spouse	84	M	Pneumonia	1:00 AM	Hospital
Child	45	F	Pneumonia	2:00 AM	Hospital
Child	46	M	Pneumonia	3:00 AM	Hospital
Parent	109	M	Heart Disease	4:00 AM	Hospital
Parent	104	F	Stroke	5:00 AM	Hospital
Spouse	85	M	Pneumonia	6:00 AM	Hospital
Child	47	F	Pneumonia	7:00 AM	Hospital
Child	48	M	Pneumonia	8:00 AM	Hospital
Parent	110	M	Heart Disease	9:00 AM	Hospital
Parent	105	F	Stroke	10:00 AM	Hospital
Spouse	86	M	Pneumonia	11:00 AM	Hospital
Child	49	F	Pneumonia	12:00 PM	Hospital
Child	50	M	Pneumonia	1:00 PM	Hospital
Parent	111	M	Heart Disease	2:00 PM	Hospital
Parent	106	F	Stroke	3:00 PM	Hospital
Spouse	87	M	Pneumonia	4:00 PM	Hospital
Child	51	F	Pneumonia	5:00 PM	Hospital
Child	52	M	Pneumonia	6:00 PM	Hospital
Parent	112	M	Heart Disease	7:00 PM	Hospital
Parent	107	F	Stroke	8:00 PM	Hospital
Spouse	88	M	Pneumonia	9:00 PM	Hospital
Child	53	F	Pneumonia	10:00 PM	Hospital
Child	54	M	Pneumonia	11:00 PM	Hospital
Parent	113	M	Heart Disease	12:00 AM	Hospital
Parent	108	F	Stroke	1:00 AM	Hospital
Spouse	89	M	Pneumonia	2:00 AM	Hospital
Child	55	F	Pneumonia	3:00 AM	Hospital
Child	56	M	Pneumonia	4:00 AM	Hospital
Parent	114	M	Heart Disease	5:00 AM	Hospital
Parent	109	F	Stroke	6:00 AM	Hospital
Spouse	90	M	Pneumonia	7:00 AM	Hospital
Child	57	F	Pneumonia	8:00 AM	Hospital
Child	58	M	Pneumonia	9:00 AM	Hospital
Parent	115	M	Heart Disease	10:00 AM	Hospital
Parent	110	F	Stroke	11:00 AM	Hospital
Spouse	91	M	Pneumonia	12:00 PM	Hospital
Child	59	F	Pneumonia	1:00 PM	Hospital
Child	60	M	Pneumonia	2:00 PM	Hospital
Parent	116	M	Heart Disease	3:00 PM	Hospital
Parent	111	F	Stroke	4:00 PM	Hospital
Spouse	92	M	Pneumonia	5:00 PM	Hospital
Child	61	F	Pneumonia	6:00 PM	Hospital
Child	62	M	Pneumonia	7:00 PM	Hospital
Parent	117	M	Heart Disease	8:00 PM	Hospital
Parent	112	F	Stroke	9:00 PM	Hospital
Spouse	93	M	Pneumonia	10:00 PM	Hospital
Child	63	F	Pneumonia	11:00 PM	Hospital
Child	64	M	Pneumonia	12:00 AM	Hospital
Parent	118	M	Heart Disease	1:00 AM	Hospital
Parent	113	F	Stroke	2:00 AM	Hospital
Spouse	94	M	Pneumonia	3:00 AM	Hospital
Child	65	F	Pneumonia	4:00 AM	Hospital
Child	66	M	Pneumonia	5:00 AM	Hospital
Parent	119	M	Heart Disease	6:00 AM	Hospital
Parent	114	F	Stroke	7:00 AM	Hospital
Spouse	95	M	Pneumonia	8:00 AM	Hospital
Child	67	F	Pneumonia	9:00 AM	Hospital
Child	68	M	Pneumonia	10:00 AM	Hospital
Parent	120	M	Heart Disease	11:00 AM	Hospital
Parent	115	F	Stroke	12:00 PM	Hospital
Spouse	96	M	Pneumonia	1:00 PM	Hospital
Child	69	F	Pneumonia	2:00 PM	Hospital
Child	70	M	Pneumonia	3:00 PM	Hospital
Parent	121	M	Heart Disease	4:00 PM	Hospital
Parent	116	F	Stroke	5:00 PM	Hospital
Spouse	97	M	Pneumonia	6:00 PM	Hospital
Child	71	F	Pneumonia	7:00 PM	Hospital
Child	72	M	Pneumonia	8:00 PM	Hospital
Parent	122	M	Heart Disease	9:00 PM	Hospital
Parent	117	F	Stroke	10:00 PM	Hospital
Spouse	98	M	Pneumonia	11:00 PM	Hospital
Child	73	F	Pneumonia	12:00 AM	Hospital
Child	74	M	Pneumonia	1:00 AM	Hospital
Parent	123	M	Heart Disease	2:00 AM	Hospital
Parent	118	F	Stroke	3:00 AM	Hospital
Spouse	99	M	Pneumonia	4:00 AM	Hospital
Child	75	F	Pneumonia	5:00 AM	Hospital
Child	76	M	Pneumonia	6:00 AM	Hospital
Parent	124	M	Heart Disease	7:00 AM	Hospital
Parent	119	F	Stroke	8:00 AM	Hospital
Spouse	100	M	Pneumonia	9:00 AM	Hospital
Child	77	F	Pneumonia	10:00 AM	Hospital
Child	78	M	Pneumonia	11:00 AM	Hospital
Parent	125	M	Heart Disease	12:00 PM	Hospital
Parent	120	F	Stroke	1:00 PM	Hospital
Spouse	101	M	Pneumonia	2:00 PM	Hospital
Child	79	F	Pneumonia	3:00 PM	Hospital
Child	80	M	Pneumonia	4:00 PM	Hospital
Parent	126	M	Heart Disease	5:00 PM	Hospital
Parent	121	F	Stroke	6:00 PM	Hospital
Spouse	102	M	Pneumonia	7:00 PM	Hospital
Child	81	F	Pneumonia	8:00 PM	Hospital
Child	82	M	Pneumonia	9:00 PM	Hospital
Parent	127	M	Heart Disease	10:00 PM	Hospital
Parent	122	F	Stroke	11:00 PM	Hospital
Spouse	103	M	Pneumonia	12:00 AM	Hospital
Child	83	F	Pneumonia	1:00 AM	Hospital
Child	84	M	Pneumonia	2:00 AM	Hospital
Parent	128	M	Heart Disease	3:00 AM	Hospital
Parent	123	F	Stroke	4:00 AM	Hospital
Spouse	104	M	Pneumonia	5:00 AM	Hospital
Child	85	F	Pneumonia	6:00 AM	Hospital
Child	86	M	Pneumonia	7:00 AM	Hospital
Parent	129	M	Heart Disease	8:00 AM	Hospital
Parent	124	F	Stroke	9:00 AM	Hospital
Spouse	105	M	Pneumonia	10:00 AM	Hospital
Child	87	F	Pneumonia	11:00 AM	Hospital
Child	88	M	Pneumonia	12:00 PM	Hospital
Parent	130	M	Heart Disease	1:00 PM	Hospital
Parent	125	F	Stroke	2:00 PM	Hospital
Spouse	106	M	Pneumonia	3:00 PM	Hospital
Child	89	F	Pneumonia	4:00 PM	Hospital
Child	90	M	Pneumonia	5:00 PM	Hospital
Parent	131	M	Heart Disease	6:00 PM	Hospital
Parent	126	F	Stroke	7:00 PM	Hospital
Spouse	107	M	Pneumonia	8:00 PM	Hospital
Child	91	F	Pneumonia	9:00 PM	Hospital
Child	92	M	Pneumonia	10:00 PM	Hospital
Parent	132	M	Heart Disease	11:00 PM	Hospital
Parent	127	F	Stroke	12:00 AM	Hospital
Spouse	108	M	Pneumonia	1:00 AM	Hospital
Child	93	F	Pneumonia	2:00 AM	Hospital
Child	94	M	Pneumonia	3:00 AM	Hospital
Parent	133	M	Heart Disease	4:00 AM	Hospital
Parent	128	F	Stroke	5:00 AM	Hospital
Spouse	109	M	Pneumonia	6:00 AM	Hospital
Child	95	F	Pneumonia	7:00 AM	Hospital
Child	96	M	Pneumonia	8:00 AM	Hospital
Parent	134	M	Heart Disease	9:00 AM	Hospital
Parent	129	F	Stroke	10:00 AM	Hospital
Spouse	110	M	Pneumonia	11:00 AM	Hospital
Child	97	F	Pneumonia	12:00 PM	Hospital
Child	98	M	Pneumonia	1:00 PM	Hospital
Parent	135	M	Heart Disease	2:00 PM	Hospital
Parent	130	F	Stroke	3:00 PM	Hospital
Spouse	111	M	Pneumonia	4:00 PM	Hospital
Child	99	F	Pneumonia	5:00 PM	Hospital
Child	100	M	Pneumonia	6:00 PM	Hospital
Parent	136	M	Heart Disease	7:00 PM	Hospital
Parent	131	F	Stroke	8:00 PM	Hospital
Spouse	112	M	Pneumonia	9:00 PM	Hospital
Child	101	F	Pneumonia	10:00 PM	Hospital
Child	102	M	Pneumonia	11:00 PM	Hospital
Parent	137	M	Heart Disease	12:00 AM	Hospital
Parent	132	F	Stroke	1:00 AM	Hospital
Spouse	113	M	Pneumonia	2:00 AM	Hospital
Child	103	F	Pneumonia	3:00 AM	Hospital
Child	104	M	Pneumonia	4:00 AM	Hospital
Parent	138	M	Heart Disease	5:00 AM	Hospital
Parent	133	F	Stroke	6:00 AM	Hospital
Spouse	114	M	Pneumonia	7:00 AM	Hospital
Child	105	F	Pneumonia	8:00 AM	Hospital
Child	106	M	Pneumonia	9:00 AM	Hospital
Parent	139	M	Heart Disease		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14192 CERTIFICATE OF DEATH

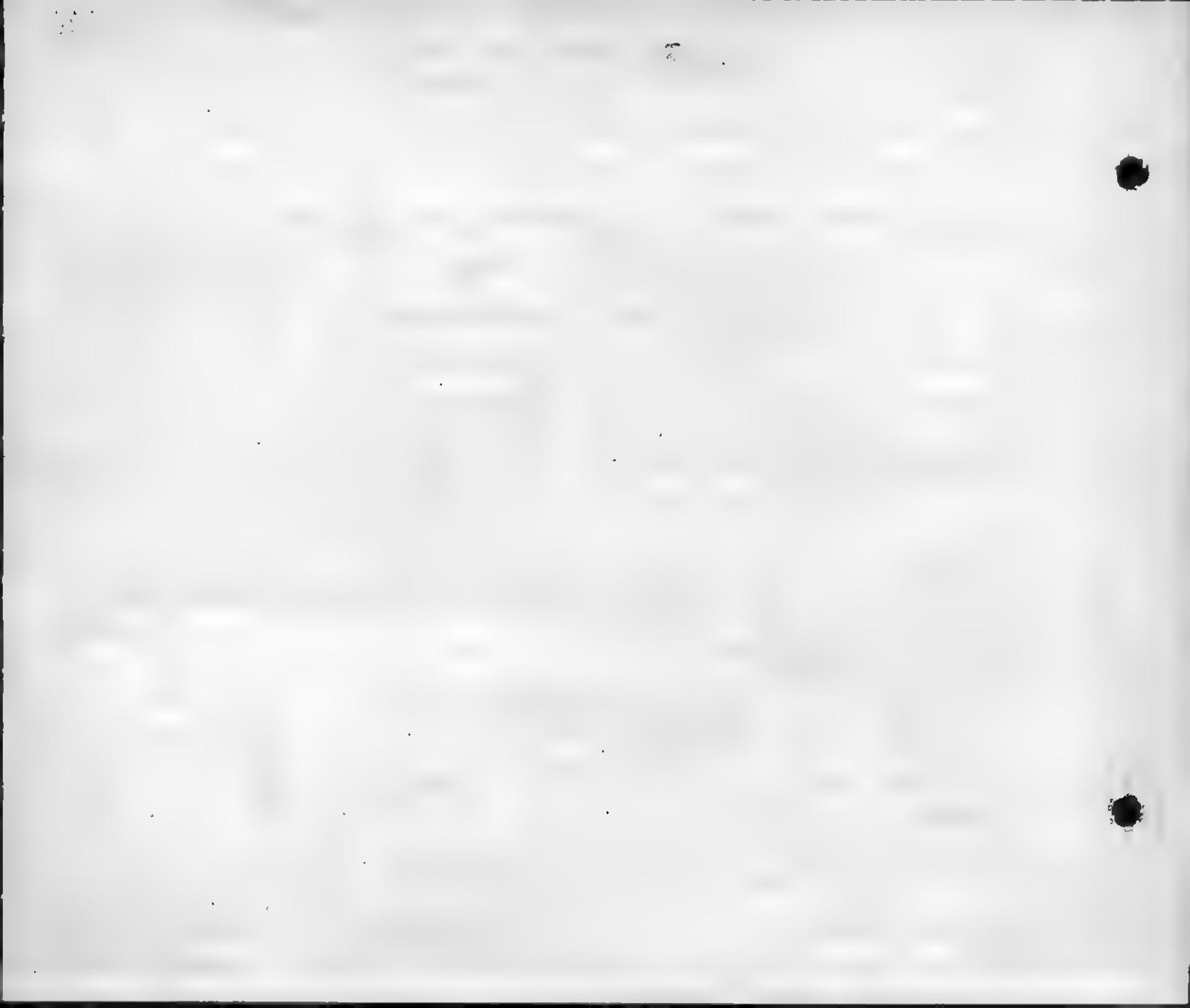
Reg. Dist. No.

14182

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Plaster</i>		c. LENGTH OF STAY IN 1b <i>all about</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS <i>Dormition</i>	
3. NAME OF DECEASED (Type or print) FRANK HARRISON		First <i>Lee</i>	Middle <i>Harrison</i>
4. DATE OF DEATH <i>Dec 22 1958</i>		Month <i>Dec</i>	Day <i>22</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Nov 27 1884</i>		9. AGE (in years from last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Waterman</i>	11. BIRTHPLACE (State or foreign country) <i>Wilmington Del.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Francis Lee</i>	
14. MOTHER'S MAIDEN NAME <i>Raphael Gurn Speerly</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>212-20-9836</i>		17. INFORMANT <i>Marcella Lee Chester Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>400.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>hypertensive cardio-vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Dec 22 1958</i>	
(b) DUE TO <i>Arteriosclerosis generalized cerebral</i>		about 5 years	
(c)		about 5 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>W</i>		20f. (City or town) <i>W</i>	
(County) <i></i>		(State) <i></i>	
21. I certify that I attended the deceased from <i>May 10 1958</i> to <i>Dec 22 1958</i> , that I last saw the deceased alive on <i>Dec. 22 1958</i> , and that death occurred at <i>5:10 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodor Sattelmayer M.D.</i>		ADDRESS (Street, city or town, state) <i>Stevensville</i>	
PHYSICIAN'S NAME (Type) <i>Theodor SATTELMAYER M.D.</i>		DATE SIGNED <i>Dec 23 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 24 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Stevensville</i>		22d. LOCATION (City, town, or county) <i>Stevensville Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Smith Doctor Bass (Bactericid Med.)</i>		24a. REC'D BY REGISTRAR <i>Dec 24 1958</i>	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i>John S. Moore</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14184

14193 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>	c. LENGTH OF STAY IN 1b <i>Thirty days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>	d. COUNTY <i>Queen Anne's</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	d. STREET ADDRESS <i>1 Burrsocelle</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>APPHIE</i>	First <i>G.</i>	Middle <i>REILLY</i>	Last <i>Lee</i>		
4. DATE OF DEATH <i>Dec 17 1958</i>	Month <i>Dec</i>	Day <i>17</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14-1897</i>		
9. AGE (In years last birthday) <i>61 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Stevensville Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Philip Reilly</i>	14. MOTHER'S MAIDEN NAME <i>Rebecca Reilly</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-30-8026</i>	17. INFORMANT <i>Ethel R. Johnson daughter, Centreville Md</i>	Address <i>P.F.B.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>421.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	INTERVAL BETWEEN ONSET AND DEATH <i>Chronic valvular disease of the heart</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Dec 17 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1 Burrsocelle</i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>Dec 1</i> , 1958 to <i>Dec 17</i> , 1958 that I last saw the deceased alive on <i>Dec 15</i> , 1958, and that death occurred on <i>Dec 17</i> , 1958, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Burrsocelle Md</i>					
ACTUAL SIGNATURE <i>H. F. McPherson</i>	DATE SIGNED <i>17/12/58</i>				
PHYSICIAN'S NAME (Type) <i>H. F. McPherson</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 20-1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>1 Burrsocelle</i>	22d. LOCATION (City, town, or county) <i>In Centreville Maryland</i>	(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. F. McPherson</i>	ADDRESS <i>61 Fairview Building, Centreville, Maryland</i>	24a. REC'D BY REGISTRAR <i>REC 23 '58</i>	24b. REGISTRAR'S SIGNATURE <i>S. L. S. Khan</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14194 CERTIFICATE OF DEATH

Reg. Dist. No.

14185

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		c. LENGTH OF STAY IN lb		d. STATE Md.		b. COUNTY Kent.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walraven Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St' ll Pond		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
f. STREET ADDRESS 14 X - 2								
3. NAME OF DECEASED (Type or print) CARRIE		First	Middle	Last	4. DATE OF DEATH	Month December	Day 5	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years less birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Still Pond, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John H. Harding				14. MOTHER'S MAIDEN NAME Caroline Scotten				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Julian O.Scofield,		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1		DUE TO		<i>Paste Culture Adulteration</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO		<i>Clinical myocardiad</i>				
		(c)		<i>General Circumstances</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				<i>Psych</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>20</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Dec 4</i> , 1958, to <i>Dec 5</i> , 1958, that I last saw the deceased alive on <i>Dec 4</i> , 1958, and that death occurred at <i>2 p.m.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Georgetown</i>		
ACTUAL SIGNATURE <i>@ Whitecoll</i>		M.D.		<i>P. L. Carr</i>		DATE SIGNED <i>Dec 12/12/58</i>		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Georgetown Cem.		22d. LOCATION (City, town, or county) Georgetown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows, Wellington, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DEC 10 1958 DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i>		

81 [COMMITTEE ON THE MONETARY SYSTEM](#) - 14 JULY 1944

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14195 CERTIFICATE OF DEATH

Reg. Dist. No.

14187

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queenstown			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Melbinston (Princeton) 3 weeks		c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sallie Warren Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RFD Centerville 1 Bevansville			
3. NAME OF DECEASED First CLARENCE H WILSON		4. DATE OF DEATH Month Dec Day 29 Year 1938			
e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 5-1873		
9. AGE (In years, months and days)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Farm owner	10c. BIRTHPLACE (State or foreign country) Queen Anne's Co Md	11. CITIZEN OF WHAT COUNTRY? USA
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph Wilson		14. MOTHER'S MAIDEN NAME do not know - Hester?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16. SOCIAL SECURITY NO. None		17. INFORMANT Edward Wilson 1012 Homestead Washington D.C.	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Cerebral Hemorrhage			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Adult Polio			
DUE TO					
(c)		Chronic Myocarditis			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Sputum			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 71		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 10, 1938, to Dec 29, 1938, that I last saw the deceased alive on Dec 24, 1938, and that death occurred at 6 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. W. E. Leibell M.D.		Leibell Dec 14/38/38			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 2 - 1939		22b. DATE THEREOF ADDRESS		22c. NAME OF CEMETERY OR CREMATORIUM Bevansville	
22d. LOCATION (City, town, or county) (State) Bevansville W. Calvertown Md					
23. FUNERAL DIRECTOR'S SIGNATURE W. Evans Baileya, Baileya & Baileya Funeral Home		24a. REC'D BY REGISTRAR DATE JAN 7 '59		24b. REGISTRAR'S SIGNATURE C. Evans & Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEVADA—MUNICIPAL

CERTIFICATE OF NEVADA

RECEIVED

RECEIVED